Frederick Health

Welcome to Frederick Health Physical Therapy & Sports Rehab, offering Physical Therapy, Occupational Therapy, Speech Therapy, Pelvic Health Therapy, Lymphedema & Aquatic Therapy for both adults and pediatrics. Through evaluation and individualized treatment planning, our therapists will help you reach your rehabilitation goals and achieve your full potential. **You are the most important member of the treatment team!**

- To achieve the maximum benefits from your program, you must be an active participant in your program, and we ask that you attend all scheduled sessions.
- **If you are having difficulty eating or coming in for a swallowing evaluation please bring food items with you as our office does not carry these. Items can consist of applesauce, pudding, sandwich, pretzels, crackers, fruits etc., and liquid such as water or juice.**
- Please make every effort to be on time for your appointment. Your therapist may need to shorten your visit if you are late to avoid inconveniencing patients who follow. If you are more than 15 minutes late, we reserve the right to reschedule your appointment.
- Please call our office when you must cancel a scheduled appointment. **Failure to cancel a scheduled appointment** will be considered a **no show. PLEASE NOTIFY US 24 HOURS IN ADVANCE IF YOU CAN NOT MAKE YOUR APPOINTMENT. After three (3) no shows or cancellations, you may be discharged and your doctor will be notified.** If this occurs, you will need to return to your doctor for a new prescription to resume therapy.
- If you suspect that you may have or have been diagnosed with a communicable/infectious disease such as shingles, pink eye, strep throat, frequent or infectious diarrhea (sometimes called "C diff"), call the clinic prior to your appointment to discuss the appropriateness of your attendance with your therapist.
- Our staff makes every effort to make your treatment here a positive experience. To better assist you with the coordination of therapy as ordered by your physician, **we encourage you to know your outpatient therapy benefits.** Please take the time to review your benefit handbook or contact member services located on your member ID card.
- It is your responsibility to notify us of any changes in your insurance policy. Failure to provide accurate/ updated information may result in denial of coverage and you will assume financial responsibility.
- Please have family members and friends, unless a part of therapy, wait in the lobby. An adult **must** accompany children under 10 who are waiting in the lobby.
- **Co-payments are due at the time service is rendered and can be made at the registration desk.**

I Expect From My Therapist:

- _____
- _____
- _____

*Our Goal Is To Provide Excellent Service To **You***

Your feedback is very important in determining the effectiveness of your treatment. If you have questions, concerns or complaints, please discuss them with your therapist so adjustments can be made. We look forward to working with you.

_____ _____

Patient signature **Date** **Frederick Health Witness signature** **Date**

What Brought You To Frederick Health Physical Therapy & Sports Rehab?

□ A family member or friend told me about Frederick Health Physical Therapy & Sports Therapy

□ I saw a flyer for Frederick Physical Therapy & Sports Rehab Services

□ I read a Frederick Health Physical Therapy & Sports Rehab article in *Frederick's Child* Magazine

□ I saw Frederick Health Physical Therapy & Sports Rehab information at Health Unlimited Family Fitness

□ I heard about Frederick Health Physical Therapy & Sports Rehab on the radio

□ I attended a Frederick Health Physical Therapy & Sports Rehab seminar/event

□ I found you online:

- □ Frederick Health Website
- □ Google Search
- □ Frederick Health Social Media

□ My Insurance recommended Frederick Health Physical Therapy & Sports Rehab

□ I was a previous patient

□ My Physician referred me

Physicians Name_____

□ Another source? Please let us know!

Thank you!

Frederick Health

PATIENT MEDICAL HISTORY

Name: _____ **Date:** _____

Diagnostic Studies:

Barium Swallow: Test _____ Date _____
X-rays: Area _____ Date _____
CT Scan: Area _____ Date _____
Ultrasound: Area _____ Date _____
EMG: Area _____ Date _____
Nerve Conduction: _____ Date _____
Myelogram: Area _____ Date _____
Nuclear Medicine: Area _____ Date _____
Urinalysis: Test _____ Date _____
Biopsy: Test _____ Date _____
Mammogram: Test _____ Date _____
MRI: Area____ _____ Date _____
Additional Test's not listed: _____

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

Cardiologist Date _____
Neurologist Date _____
Oncologist Date _____
Emergency Room Date _____
Obstetrician Date _____
Physical Therapy Date _____
Occupational Therapy Date _____
Speech Therapy Date _____
Dentist Date _____
Oral Surgeon Date _____
Other Date _____

Please check all that apply, do you now have or have you ever had any of the following?

Stroke/TIA _____ _____
Hypertension _____
Difficulty Swallowing _____
Head Injury _____
Osteoarthritis _____
Fibromyalgia___ _____
Respiratory Problems _____
Voice Changes/Disorder_____
Concussion/ Head Injury_____
Kidney Disease_____
Heart Disease _____
Diabetes _____
Laryngopharyngeal Reflux _____
Paying attention/distracted easily _____
Asthma _____
Bronchitis _____
Heart attack_____
Emphysema _____
Seizures/Epilepsy_____
Weakness _____
HIV Disease/AIDS____
Developmental Dis.___
Parkinson's Disease____
Sore Throat _____
Alzheimer's Disease___
Alcoholism/Illicit drug use____
Memory Loss _____
Angina _____
Fatigue _____
Headaches _____
Depression _____
Cancer _____
Multiple Sclerosis ____
Thyroid Disease_____
Hepatitis _____
Tuberculosis _____
Hepatitis _____
COPD _____
Reflux/GERD _____
Speaking clearly_____

If you checked any of the following, please provide the date and any additional information here:

_____

_____

Allergies: Yes _____(Please list below) No _____

_____

Do you Smoke? Yes___ No___ Packs/Day _____

Patient/Guardian Signature: _____ Date _____

Clinician Signature:_____ Date _____

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	Dose	How and How Often You Take the Medication	Reason for taking	Date Started	Prescriber

Patient Signature_____ Date:_____